THE DIFFERENTIATION OF NEUROSES AND PSYCHOSES, WITH SPECIAL REFERENCE TO STATES OF DEPRESSION AND ANXIETY.

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THE problem of the differentiation between neurosis and psychosis has given rise to much confused literature and discussion. This is particularly true of those cases in which anxiety or depression is the outstanding feature of the illness, and which do not show any gross symptoms of psychotic illness. Such confusion as exists appears to be due to a variety of causes. For example, the social implications of psychotic illness tend to favour a diagnosis of neurosis in many of the milder cases. Again, the same diagnostic terms are often used with quite different meanings by different workers. An even more potent cause of difficulty is the temptation to search for fixed disease entities in psychiatry which can be sharply separated one from the other.

This is a cardinal error, and it has often stultified attempts to introduce orderly methods of classification. It is, no doubt, dangerous in all branches of medicine to think in rigid diagnostic terms, since once the case has been suitably labelled, important individual differences may easily be overlooked. In psychiatry the complication and variability of the factors involved make the setting up of such fixed categories particularly harmful. Certain broad principles may, however, be found which enable us to group together a series of cases under a common heading. This heading, if it is to be of value, should help us to appreciate the factors which are similar in the series without losing sight of individual differences. It is in this spirit that we have to approach any problem of psychiatric classification.

The problem under discussion must first be formulated as clearly as possible. It is really a twofold one. Firstly, whether there is any essential difference between a neurosis and a psychosis. Secondly, whether there is any essential difference between that group of cases commonly termed psychoneurotic anxiety states, anxiety neuroses or anxiety reactions and that group commonly termed depressions. Unfortunately the problem is made even more complex by the fact that the first group is frequently termed neurotic and the second psychotic, this differentiation being made by previous definition of the groups and not by any appeal to clinical judgment.

It may be said that there are those who regard the concept of neurosis in

general and anxiety neurosis in particular as valuable and important, to be differentiated carefully from psychosis and psychotic depression. There are also those who regard these differences as incidental, misleading, and often quite unimportant. A few references from recent literature will serve to illustrate the difficulty.

In this country T. A. Ross has been a leading exponent of the view that there is a fundamental difference between anxiety reactions and depressions. His definition of the anxiety reaction may be accepted as a good one (1927), i.e. " Those patients whose chief symptom is either frank mental anxiety or its somatic manifestations, of which palpitations, sweating, flushing and tremor are the chief." It will be noted that he does not mention depression in this definition, and in another place (*The Common Neuroses*, chapter upon the " Symptomatology of Anxiety States ") he does not record it as one of the symptoms of the illness at all.

He lays stress upon the differentiation from the group of depressions for various reasons, among which prognosis, therapy and suicidal risk may be mentioned. In his view the diagnosis may be established by a number of indications. In the history of the case the depressive attack frequently comes out of the blue; there may be a story of previous attacks of depression, and the personality of the patient may be surprisingly normal between the attacks. The neurotic, on the other hand, is seldom completely well between his attacks, which are closely related to psychological difficulties. The depression itself is of a different type in the two disorders. In the psychotic it is independent of the environment; in the neurotic, environment makes a great difference. The psychotic tends to blame himself for his troubles, the neurotic tends to blame others. Other notable differences, according to Ross, are rapid variations of mood in the neurotic, retardation of mind and body and lack of insight in the psychotic.

If the differentiation to be made was truly one between anxiety on the one hand and depression on the other, most of this differential diagnosis would be beside the point. Ross is clearly, however, accepting the fact that in practice the diagnosis may have to rest, not upon the separation of anxiety and depression, but at least in some cases upon a distinction between two different types of depression. His reluctance to speak of the symptom of depression in connection with the anxiety reactions may perhaps be due to the tendency already mentioned to regard depressive illnesses as properly belonging to the psychoses, whereas all the cases he has in mind should, in his view, be regarded as neuroses. A possible source of confusion is here evident, since cases in which depression is the leading feature of the illness may be forced into the category of anxiety states in order to emphasize their relationship with the neuroses.

Gillespie, among many others, has attempted to solve this problem by setting up a group of psychoneurotic depressions closely allied to the anxiety states, but in which depression and not anxiety is the leading symptom.

These he differentiates from psychotic depression in various ways, but chiefly by their greater " reactivity." By reactivity he implies the variability of the affective condition in relation to internal or external factors (topics of pre-occupation) of a conscious kind. In this respect Gillespie is, of course, following in the footsteps of many other writers (notably J. Lange), who have attempted to make a clinical differentiation from the classical endogenous manic-depressive insanity of Kraepelin.

Thus a consideration of the views of these two writers leads to the conclusion that there exists a complex group of cases marked by symptoms of anxiety or depression and belonging essentially to the neuroses. These can be differentiated from a group of depressions which belong to the psychoses.

These views have been strongly endorsed by other writers. For example, Yellowlees (1932), speaking of this type of case stated : " Neurotics generally are made, not born. I believe it to be far otherwise with the psychoses, the causes of which are more deeply and more mysteriously biological. Psychotics are born, not made." Again (1930), in a similar context, there is " a difference in kind as well as a difference in degree." Crichton Miller contrasts the group of cyclothymic depressions (psychotic) with the group of neurotics. He says, " The true cyclothymic varies for endogenous reasons, and all other explanations are fallacies of lay observation."

Quite contrary views have, however, been put forward by other writers, whose opinion must now be recorded.

In the 1937 edition of Price's *Textbook of Medicine*, Mapother and Lewis place the anxiety states under a sub-heading in the group of affective reactions, and consider the diagnosis and treatment of this group along with the rest of the affective states. They state, " The distinction between neurosis and psychosis is at times convenient, but without substance." An anxiety state is, therefore, but a mild form of agitated depression. In another place Lewis (1934) writes, " One cannot set up the symptom anxiety as an independent type of reaction," and he quotes other authors, e.g. Birnbaum, in support of this statement. In the same paper he also concludes that views on the existence of two varieties of depression (i.e. neurotic and psychotic) are false.

Curran took two groups of cases suffering from anxiety and depression, the one supposedly neurotic, the other psychotic. He compared various features of the two groups, and came to the conclusion that no list of criteria for differential diagnosis could be found. Indeed, his paper clearly demonstrates the futility of what may be termed " diagnosis by category," and the impracticability of drawing up such lists to differentiate between one reaction type and another.

Symonds has summarized the essential features of this viewpoint in the following remarks : " The affective type of mental disorder . . . may be either of the neurotic degree (anxiety neurosis, neurotic depression) or the psychotic degree (manic-depressive psychosis) . . . there is in my view

no essential difference between a neurosis and a psychosis except that of degree."

Such, then, is the essence of the conflict of views—a conflict which is as old as Kraepelin's first formulation of manic-depressive psychosis. This brief résumé of some recent views is intended to do no more than illustrate it. The problem as stated is a twofold one, namely whether it is possible to differentiate between neurosis and psychosis, on the one hand, and between anxiety states and depressions on the other hand. Unless its twofold nature is clearly emphasized confusion is bound to arise, as it has so often in the past.

A few more definitions may be helpful at this point. Ross's definition of an anxiety state already given may be accepted as a good one. Lewis (1938) has defined a depression in the psychological sense as follows: "Any person who is unhappy and ill with his unhappiness may properly be said to be in a state of depression." He proceeds to eliminate from this definition other conditions, psychotic and organic, in which depression may also be a prominent symptom.

With regard to the definition of the term "neurosis," Mapother and Lewis suggest that it is permissible to term a patient "neurotic" if he has insight into his illness, is co-operative, and unlikely to need care in an institution. The first of these three points is sometimes difficult to determine satisfactorily, and has, in fact, been criticized by Lewis himself (1934) in another place. It may perhaps be taken to mean that the patient realizes that he is ill and appreciates the extent of his symptoms. All three points, in fact, depend upon one cardinal factor, namely, that the patient's relationship with reality remains fundamentally intact. This is the point stressed by Ross, who states, "The psychotic lives, in so far as he is a psychotic, in a world of phantasy; the neurotic lives in the real world." This is a point which is implied in Meyer's definition of a neurosis as a "merergasia" or "part reaction." (The same author [1912], in connection with a different type of case, but none the less aptly, speaks of the degree of "deficiency in corrigible foundation and relation to things as they are.")

We have arrived at what is obviously a *clinical* distinction between neurosis and psychosis. We have adduced so far no aetiological and no pathological basis for a differentiation. Is it then of any importance? Can we say, with Mapother and Lewis, that it is "at times convenient but without substance," or should we on the other hand agree with Ross, who "entertains no such view"?

In order to be justified any classification must, as Lewis (1938) points out, be both useful and valid. In the present state of our knowledge, no classification can be devised which shall be universally valid for research worker and clinician alike. It can, however, be valid within certain limits which can be defined, and it can also be useful. The question then is whether this differentiation serves a useful purpose to the clinician. There can be no doubt that

it is a question which is regarded as enormously important by the layman, often in a misguided sense.

The case material of the Cassel Hospital may help to provide an answer. Over a period of nearly 20 years the hospital has admitted for treatment a large number of cases, of which very many have suffered from symptoms of anxiety or depression and have been diagnosed as neuroses before admission. It is, therefore, in the highest degree relevant to refer to this bulk of clinical material for a solution of the problem.

It would be an impossible task to make an abstract of the important features of all these cases; instead it is proposed to present briefly three cases, typical of so many that have passed through the hospital, in which the outstanding symptoms have been depression. Even in these the volume of facts makes it necessary to leave out much that might be relevant if other problems were under consideration, e.g. family history, etc.

CASE 1.—W—, the manager of a steel works, a married man, aged 50, of Welsh extraction, was seen in his eleventh attack of depression. He complained of depression, feeling of worthlessness, lack of concentration and sleeplessness. Each of the previous attacks had lasted for a period of about two months. There had also been three or four mild attacks of elation in the intervening period. The present illness lasted for approximately the same time and cleared up completely without being succeeded by elation. No psychogenic factors to which any importance could be attached were found. Nine of the previous attacks had occurred in the springtime between the months of February and April. There appeared to be no special features of his life which might produce abnormal strain at this time. There was no scope in treatment for psychotherapy of an analytic kind; on the other hand, the patient's response to the daily encouragement of his physician was quite good.

If there were no demonstrable psychogenic factors in the illness there were also no physical ones. It came mysteriously "out of the blue," and one is free either to accept the Kraepelinian theory of an endogenous origin or to suppose that the psychogenic factors remained undiscovered. MacCurdy's work suggests that the latter may be the correct explanation. The history taken may have failed to reveal the true psychogenesis of the condition.

Most clinicians would regard this illness as a mild psychosis. The patient's relationship with reality was undoubtedly disordered by the mood change from which he suffered. This mood change did not bear any immediate relationship to his environmental situation, nor did it appear to be dependent upon his conscious or near-conscious preoccupations. On the contrary, these preoccupations appeared to be the result of the mood change, which had an ebb and flow of its own. Profoundly unconscious factors may have determined the tide of his mood, but there was none of the direct cause and effect relationship with an external situation which accounts for "normal" periods of depression.

It is true that reassurance and sympathy made him feel slightly better for the moment, but that would be likely to happen unless the relationship with the external world had become altogether distorted.

The next case presents a contrast in that certain precipitating factors of a fairly adequate kind could be demonstrated.

CASE 2.—S—, female, unmarried, aged 31, was admitted to hospital with a diagnosis of manic-depressive psychosis. She was depressed and tearful and had considerable sleep disturbance. The present could be said to be the third attack of her illness. She was the youngest of five children and had an unhappy childhood abroad. She came to England at the age of 9, and was educated somewhat unwillingly by relatives. At 17 she took up a career of physical training, which was made more difficult by a series of troubles involving the Head of the College, and her relations who interfered in her affairs. Her physical health was poor, and she feared that she would not be able to hold an independent job when she qualified. She became depressed and sleepless, and was advised to take a rest. After a few weeks she was able to return satisfactorily to work. She remained well for two years, and then, tasting the fruits of independence through the job she held, she became involved with a group of well-to-do and hard-living people. She lived a gay life for a while, got into financial difficulties and became depressed again. On this occasion her illness was complicated by differences of opinion among her relatives as to how she should be treated, and she was ill for several months. She recovered eventually, and having regained her precious freedom began once more to lead a somewhat over-active life with a series of not entirely satisfactory love affairs. After one of these she again became depressed and was later admitted to hospital.

During the first part of her stay in hospital the patient's symptoms bore quite a close resemblance to those of the previous case. It appeared from the history that the mood changes had been produced in the first place by the factors briefly outlined. When the significant factors in the case-history were touched upon a marked emotional reaction was produced in the patient. But it was also observed that, as in the previous case, there was an undercurrent of depression which was fairly constantly present. In other words, the mood change, once produced, pursued a course at least partly independent of the environmental problems. That which started as a mood of depression in response to a difficulty had become to some extent a primary factor in itself.

Cases of this type are often given the most widely varying labels, ranging from " neurosis " to " manic-depressive psychosis." Whether or not such a patient should be called " manic-depressive " is not at the moment relevant, though this label is often used with such a strongly nosological flavour as to hamper a proper understanding of the case. The mood change had, however, become partly dissociated from immediate environmental factors just as in

the previous case. For the same reason, therefore, the patient must be termed psychotic.

The next case to be described is one in which the depression was also the leading symptom. Here, however, the mood change appeared to be almost wholly dependent upon immediate topics of preoccupation of a conscious or co-conscious kind. It had not become groundless, but varied sharply according to these topics of preoccupation.

CASE 3.—G. W—, male, aged 39, complained of intense feelings of depression, faintness, trembling and fear. For five years before admission he had suffered from a pain in his back. Six months before admission he went to a specialist, who found that he was suffering from spondylitis deformans and prescribed a belt for him to wear. Very shortly afterwards he began to suffer from giddy turns and later had a " nervous collapse." He suffered from a wide variety of symptoms at this time, and was referred to a neurologist, who could find no evidence of organic disease except for the mild degree of spondylitis deformans. He was accordingly sent to hospital for psychological treatment.

The previous history was explanatory of the condition. He was an only son, and his father was superintendent of a large cemetery of 800 acres in the middle of which he had a house. Social life, both for the boy and his parents, was therefore very limited. The boy had no companions, but would play solitary games among the gravestones. His mother worried greatly over him, and he was always being kept away from school lest he should " overdo it." Whenever he was ill her anxiety was intensified, and the picture formed in his mind was not made less gloomy by the fact that from his bedroom he could hear the sound of coffins being made.

When he was 14 the family moved away from this house and he trained in secretarial work and later found a job. He was always anxious about his health, though he kept fairly well at this time. He married and got promotion, worrying a good deal, but always being able to carry on his work. When the pain in his back started he at first ignored it, and later got palliative treatment from his doctor. He feared that it might prove to be something terrible and tried to conceal his worry about it. When he overheard the specialist's verdict that he was suffering from spondylitis deformans, and that it was incurable, he became panic-stricken. He would not accept his own doctor's reassurances, which he thought were just to cheer him up. He was convinced that he had a terrible disease, and developed acute symptoms of depression and anxiety. These only added to his worry and so, as is often the case, set up a vicious circle and made him worse.

On admission he presented the symptoms already described. His depression, which was closely associated with anxiety, showed even more marked fluctuation than in the last case. It was much more completely determined by the immediate content of his mind. When something happened which reinforced his worry about himself he felt terribly depressed. When his

thoughts were distracted by occupation or recreation he showed marked improvement. There was none of the spontaneous morning-evening variation shown by the last two cases. When he appeared to be worse in the morning, it was found to be in response to something which had happened since the previous evening.

The case was in fact a psychoneurosis in the sense in which we have defined it. The patient's relationship with reality had undergone no fundamental change. His mood had a corrigible foundation and bore a proper relationship to his preoccupations.

We have thus described three cases in which the outstanding symptom was depression. They all represent well-recognized and quite common syndromes. Two of them appear to be psychotic and one psychoneurotic, using the differentiation discussed. This differentiation is concerned only with the patient's relationship to reality in a broad sense. It has not been made on the basis of "reactivity"; otherwise Cases 2 and 3 would have to be differentiated from Case 1; nor on a basis of mildness or severity, in which Case 1 would have to be picked out as being symptomatically at least milder than Cases 2 and 3. It cannot be made on an exclusive "either-or" basis, since obviously such a criterion as this cannot provide a sharp dividing line between neurosis and psychosis. To attempt to do so would be to fall at once into what Meyer (1928) has called "the arch sin of modern psychiatry—i.e. blinding oneself to the specific facts of the case at hand by asking at once, 'Is it a major psychosis?'" It is of the utmost importance to be clear about what the differentiation does not achieve. One may now inquire whether, within its proper limits, it is valuable and important. The answer is in the affirmative upon three grounds—psychopathology, treatment and prognosis.

To take these in what is medically their logical order means to take the most speculative and difficult problem first. One does not know enough about the state of mind commonly called depression to be able to make dogmatic assertions about its psychopathology. One can only say that it occurs, in normal people, chiefly in circumstances of loss or bereavement. Under these circumstances it persists for a certain length of time and then fades away. It may become abnormal for a variety of reasons. For example, the patient may show an excessive mood reaction to a comparatively trivial situation. This occurred in Case 3. The patient had a reason for his depression. It arose out of his anxiety about his health. But his anxiety about himself was greater than it need have been in the actual situation. It depended upon the lifelong tendency he had developed towards over-concern about his health. Many unconscious associations came into play as soon as this was threatened in any way. They were quite sufficient to account for the depression, which was therefore only *apparently* disproportionate. Moreover, it was directly associated with the conscious and co-conscious preoccupations in his mind, just as would be the case in the normal individual with an adequate cause for

his depression. This is, of course, by definition typical of an illness of this group. The patient may complain of depression for which he cannot find a cause, but preoccupations will always be discoverable, based on reality, which have a cause and effect relationship to the depression. These preoccupations may depend for their intensity and emotional significance upon other, more profound, problems and frustrations, but the rationalizing function of the conscious mind still holds sway between these deeper frustrations and the problems of external reality.

It is otherwise with Cases 1 and 2. One cannot say positively what is the cause of the mood change in these patients. In Case 2 one can point to certain factors which appear to have produced the depression in the first place. But to some extent it has acquired a continuity of its own, it has become a primary factor in the illness. In Case 1 it was not possible to point to any significant aetiological factors of a psychological order. This is not to argue that there was no cause. Perhaps as a result of internal frustrations and difficulties, perhaps as a result of changes best expressed in physiological terms, a mood of depression coloured the content of the patient's mind. But whatever factors were responsible for the depression, it was clearly of a different order to that found in Case 3. The rationalizing function of consciousness no longer held sway. The mood was not related, as in the normal individual, to the problems of external reality. It was not related even to the multitude of associations and derivations which give a personal significance to the factors of external reality, and which in the neurotic can explain an apparent abnormality of mood. It was capable of colouring and distorting the patient's view of these factors, but its roots now lay in other and perhaps deeper levels of the mind.

Having thus amplified the psychopathological differences which lie behind these two groups of cases, it may be appropriate to inquire whether a differential diagnosis can be made by which the clinician can separate them in practice in the majority of instances. If the very limited deductions made are correct it should be possible to do so, but not by means of the criteria so often used. Differences in the type of depression shown by the individual case are useless. Each patient is miserable, but there is no way of differentiating the *quality* of their misery. Mildness or severity affords no clue ; an exceedingly depressed patient seen recently at the Cassel Hospital was suffering from a neurosis by the definition used here. He was an ambitious young man of 29, with a complex determined fear of failure in his job which appeared to be about to materialize. Duration varies widely with both conditions. A woman of 38 suffered from symptoms of depression for 15 years, which proved on investigation to be directly related to her home difficulties and to be neurotic in type. The presence of precipitating factors at the outset of the illness, invariable in the neurotic depression, is common also in the psychotic. Our own case material affords conclusive evidence of this. Recurrence is obviously a dangerous guide to adopt ; it is not the prerogative of a psychosis. Indeed,

for those who regard neurosis as something to be treated and psychosis as something to be left alone, it may lead to tragic results. Other superficial clinical data are almost equally unreliable, as Curran showed so conclusively. It is true that the psychotic depression tends to run a course more rhythmically variable than the neurotic, with early morning exacerbation, etc., but this is a most unsafe differential guide.

In fact the only method of arriving at the diagnosis is to study the history and day-to-day behaviour of the patient with minute care. It may then be possible to decide whether or not the mood change observed is dependent upon the preoccupations of the patient, themselves related in a proper manner, on the one hand to external reality and on the other to his instinctive strivings. Thus, as in many other medical conditions, diagnosis must still depend upon a careful study of pathology.

Differences in treatment are important, but their importance can be exaggerated. A state of depression is often broadly regarded as a defence mechanism of the individual, leading to a diminution of activity for the time being in the face of intolerable stress. Neurotic depression may best be dealt with by a direct psychotherapeutic attack upon the causal factors. This may not be at all easy, and, indeed, it may be completely unsuccessful if the patient's personality permits of little readjustment. Nevertheless, a direct attack represents the most efficient method of approach in these cases. By this is meant, firstly, an attempt to reach an understanding of the factors, both external and internal, which constitute the patient's problem. For this purpose free association or direct questioning or some other method may be employed. It will be followed by the presentation of the real nature of his problem to the patient in such a way that he can understand and act upon his understanding.

Psychotic depression is not amenable to this approach in quite the same way. Here it might be said that the defence mechanism has come into operation in a far more wholesale manner. To most workers it appears that the time factor assumes an importance in treatment which it does not have to the same extent in the previous group. The direct attack has to be much more limited, especially in the early stages. Principles of rest have to be observed as in many other conditions. The patient has to be placed in a simpler environment in which natural healing forces can come into full play. Only gradually will he be fit to face his problems and learn to deal with them in a healthier way. This is not the place to go extensively into problems of treatment, but it may be said that whereas the principles in the two groups are not really opposite, at certain stages a diametrically different approach is necessary. Rest, in the psychiatric sense, may be unnecessary or actually harmful in the neurotic ; it may be essential for a certain period in the psychotic, for whom a very active therapy at this time may be most deleterious.

Turning lastly to the question of prognosis, one cannot derive much help

from the recovery rate in the individual attack. The majority of cases of psychotic depression, but certainly not all of them, improve or recover. The majority of cases of neurotic depression also improve, but without adequate psychotherapy the degree of improvement is generally less marked than in the psychoses. Relapses occur in both types whether treated or not. Significant information can be obtained from a study of the type of attack shown in these relapses. If the difference between neurotic and psychotic depression were merely one of degree, then it would be likely that mild "neurotic" attacks and more severe "psychotic" attacks would alternate frequently in the same patients. The material of the Cassel Hospital suggests that this is not the case. Ross (1936) found that out of 1,043 patients with a diagnosis of neurosis whose cases were followed up for from 3 to 15 years, about 50 developed psychotic illnesses (i.e. less than 5 per cent.). It is true that Ross included all types of neurosis under this heading, but a considerable proportion of the cases had depression or anxiety as the leading symptom of their illness. Anxiety states and neurotic depressions are, as will be pointed out presently, very closely related. It is also true that, as a result of the methods of follow-up used, the cases had to become quite unequivocally psychotic in order to be classed under this heading. Nevertheless, the figures are impressive. They indicate that in remissions the illness did not differ very greatly, in so far as the fundamental relationship with reality was concerned, from its original form. In this respect *the reaction pattern remained essentially the same.*

All these different observations point to the same conclusion—that in the depressive states a differentiation between neuroses and psychoses is both valid and useful.

If one turns to a consideration of those conditions in which anxiety is the leading symptom of the illness, exactly the same conclusion is reached. This is because the relationship between anxiety and depression is very close. In the earlier discussion it was mentioned that conditions which are essentially depressive are often called anxiety states to emphasize their relationship to the neuroses. Herein lies an error which has produced much of the confusion that surrounds this subject. There is no doubt that anxiety *neuroses* should properly be distinguished from depressive *psychoses.* The grounds for their differentiation should, however, be the distinction between a neurosis and a psychosis, and not between anxiety and depression.

A single case will serve to illustrate this point.

CASE 4.—N. W—, female, aged 42, complained of palpitations, fears of going out and feelings of anxiety. Symptoms had been present for about four years before admission. She was an only child of elderly parents, and had been brought up very much under their eye, so that even in adult life she was afraid of hurting or angering them by independent action. She had not had much opportunity to make friends, but had had two close friendships with women of her own age. Her mother had broken these up quite ruthlessly

because she felt the patient ought to marry a particular young man. She had acquiesced in her mother's actions, but had never been able to bring herself to accept the young man's advances, as she was not in love with him. It was in this setting that the anxiety symptoms developed. During her treatment in hospital, which was lengthy and difficult, she had many severe attacks of anxiety. In every case it was found that these developed in relation to a situation which suggested, consciously or unconsciously, some aspect of her problem.

This case is clearly an anxiety neurosis of a typical, though highly complex variety. The mechanisms involved closely resemble those in Case 3, and the relationship to reality is similar in both. These then are closely allied neuroses, standing apart from Cases 1 and 2. There may be important differences between them, but the criteria used in this paper do not serve to illuminate them, and they would have to be sought in other ways. Attempts to divide a series of such cases, according to the predominance of anxiety or depression, would be a hopeless task. In many of them, now one, now the other stands out.

The close relationship between anxiety and depression becomes even more marked among affective psychoses. If one felt justified in separating anxiety and depressive neuroses, one would be equally justified in distinguishing between anxiety and depressive psychoses. Many of the conditions which are generally termed "agitated depressions" are almost perfect examples of "anxiety psychoses," yet this term is scarcely ever used, and they are grouped with the depressive psychoses without any question. An example here would be superfluous.

Thus a certain order becomes apparent in this confused subject, and one is in a position to sum up the conclusions. Affective states, showing either the predominance of anxiety or depression, fall into two groups, the neuroses and the psychoses. This differentiation is valid and useful when it is made, with due reservations, upon the grounds discussed. The psychoses, whether mainly anxious or depressed, are generally termed depressions. The neuroses, on the other hand, have frequently been termed anxiety states. It would be better perhaps to call them affective neuroses, or, if it proved useful, they might be sub-divided into anxiety and depressive neuroses. In any case the question as to whether anxiety states should be differentiated from depressions now loses much of its meaning, and must be reformulated. If this is done it may properly be said that the affective neuroses can be distinguished from the affective psychoses.

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